

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Barrett
REC'D OCT 18 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31689
Do not use this space.

1. PLACE OF DEATH *Boone* *73*
 (a) County *Boone* Registration District No. *73*
 (b) Township *1* Primary Registration District No. *3906*
 (c) City *Columbia* (d) Street No. *104 Ripley* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Mrs Eugenia Barb Gentry* *5' 3 1/2*
 (a) Residence, No. *104 Ripley* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Thomas B. Gentry*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 29th 1848*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 10 16

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Laurens County South Carolina*

FATHER
 13. NAME *Robert F. Barb*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Laurens Co. S. C.*

MOTHER
 15. MAIDEN NAME *Virginia Under Barb*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Laurens Co. S. C.*

17. INFORMANT (ADDRESS) *Mrs. J. G. Barb 411 56th St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Columbia Cembate* DATE *9-17-38*

19. FUNERAL DIRECTOR (ADDRESS) *Parker's Columbia Mo*

20. FILED *9/17/38* *Allie Selby* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 15 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 1938* to *Sept 15 1938*
 I last saw *her* alive on *Sept 13 1938* Death is said to have occurred on the date stated above, at *6.00 p.m.*
 The principal cause of death and related causes of importance were as follows:
Arterio-sclerosis
Broken hip 1936

Other contributory causes of importance:
Broken hip 1936

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *Y*
 If so, specify *E. D. Barrett*, M. D.
 (Signed) *74* (Address) *Columbia*

STATEMENT BY LICENSED EMBALMER

I, W N Whitehead, Licensed Embalmer No. 3893
hereby certify that the body recorded on the reverse side of this certificate was embalmed by W N Whitehead

..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed W N Whitehead
Licensed Embalmer No. 3893

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)